

Murder and Euthanasia Accusations Against Physicians

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Conflicts are ubiquitous in medicine, but it is difficult to imagine a physician facing a more calamitous accusation than that of murder or euthanasia.¹ In 2005, my colleagues and I published an article describing such accusations following the care of dying patients.² While it is important for law enforcement to identify and prosecute the rare medical personnel who are bona fide criminals, we were more interested in learning about unjustly charged practitioners. Our review found that doctors from any specialty providing terminal care could become the object of allegations, although many of these physicians worked under the rubric of palliative care. As a result, we subsequently developed an online research survey to be administered to members of a national palliative medicine professional society because these practitioners are most likely to be involved in the management of end-of-life cases. The overall survey findings have just been published,³ and 25 of 633 respondents (4%) reported having been formally investigated for hastening a patient's death when that was not their intention—13 while using opiates for symptom relief and 6 for using various medications while discontinuing mechanical ventilation. In one-third of these cases, a fellow member of the health care team initiated the charges against the physician. In this commentary, I intend to explore the implications of another question from the survey—one about humor and its double-edged qualities in the end-of-life setting. I will then speculate as to why accusations of hastening death are occurring and specifically why medical colleagues are charging physicians on their team with engaging in this practice.

We asked all 633 respondents, "In the last year, how often have any of the following people 'humorously' referred to you as promoting death, for example by calling you 'Dr Death?'" The survey's completion rate was 53%, the median age of the respondents was 50 years, and most (78%) were attending physicians. Nearly three-quarters of the sample (72%) reported having been the object of humorous comments at least once during the prior year. As illustrated in the Figure, most of the respondents reported that these remarks came from fellow physicians (59%), although comments also came from other health care professionals (49%), the participants' own friends or family members (47%), patients' family or friends (31%), and patients (21%).

Such jibes are not usually meant to be offensive, and each specialty in medicine is the target of some form of gallows humor. Like swearing, humor during private discourse can signal confederacy, intimacy, or understanding, while simultaneously purging negative emotions. Freud wrote extensively about jokes, maintaining that they are a means by which forbidden thoughts and feelings that society suppresses are introduced into the conscious mind.⁴ He proposed a number of interpretations to understand humor, including that wit contains and denatures a tremendous amount of hostility, laughter provides emotional catharsis, and jokes reveal more about societal attitudes at a particular time than about the particular individuals at which they are directed. Like the survey results, what jokes illustrate about medical society is that doctors and nurses are members of a pluralistic culture that clearly contains within it conflicting beliefs about end-of-life care, specifically hastening death.

When it comes to end-of-life care, I find an important insight contained in Woody Allen's quip, "I don't want to achieve immortality through my work. I want to achieve it through not dying." Fear of death is basic to the human condition, and this same anxiety no doubt underlies many of our colleagues' comments. However, Burt⁵ has suggested a more dire explanation. He hypothesizes that in Western cultural tradition, including medicine, death is not merely a fearful event but one that invariably carries with it an aura of wrongfulness and intrinsic immorality. Burt explains that choosing death through physician-patient decisions to discontinue or withhold life-prolonging treatments is "emotionally" experienced as a "murderous" hastening of death. He believes that it is virtually impossible to disentangle beneficent and aggressive motives in any individual case and that an intrinsic tension or ambivalence always accompanies such practices.

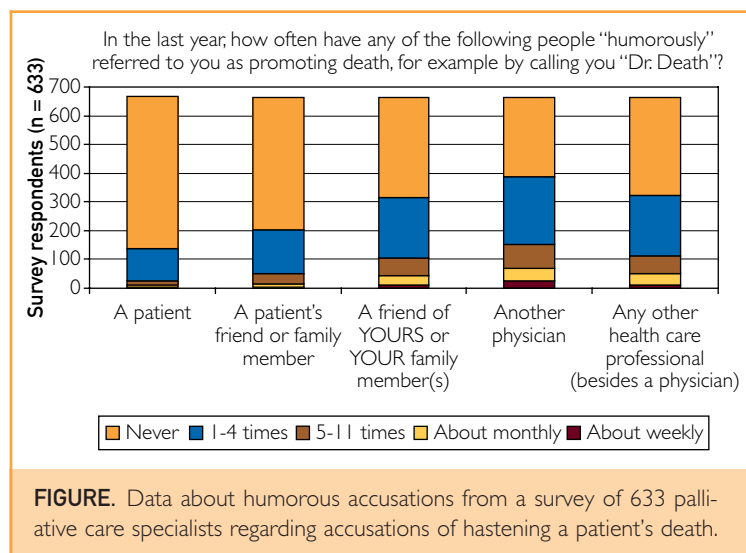
Most clinicians who care for dying patients would take umbrage at the suggestion that they actually kill patients. Palliative medicine philosophically relies on Thomas Aquinas' principle of double effect (it may be permissible to bring about as a foreseeable side effect a harmful event that would be impermissible to cause intentionally, particularly when the potential benefit outweighs the side effect's harm).⁵ It takes the position that shortening the process of dying (eg, through suppressing respiration) to ameliorate terminal suffering is entirely

justifiable. However, clinicians may neither fully appreciate nor accept that the double effect seems to many to be a philosophical “sleight of hand.” There are probably thousands of physicians and millions of Americans who believe it is improper to cite this or any principle to justify truncating life.⁶ Such individuals often instead maintain philosophies that are either *vitalist* (human existence needs to be maintained as long as possible, at any cost, and without regard to quality of life) or *theist* (it is a mortal sin to attempt to assume what is rightfully God’s control over the manner of one’s death).¹

In the United States, a societal schism became apparent following the court-ordered removal of Terri Schiavo’s feeding tube; vivid images were repeatedly broadcast of protestors marching on Hospice House Woodside in Pinellas County, Florida, with placards denouncing “Hospice Auschwitz” and “Murderers!”⁷ Although similar sentiments had been expressed in the Karen Ann Quinlan, Nancy Cruzan, and other seminal right-to-die cases, until the Schiavo-Schindler family feud, most Americans were unaware of a societal fault line running through end-of-life care.⁸ Specific practices, including administering narcotics for symptom relief, even unto death, and stopping life-support treatments (especially artificial nutrition and hydration) are anathema to a segment of the population, even though they are routine in most medical settings and accepted by mainstream bioethics and the law.⁹ According to one recent poll, 29% of the general public endorse a preference for using every possible medical intervention in order to prolong patients’ lives rather than relieving pain and enhancing quality of life.¹⁰

This is not merely an American but a global conflict.¹ Eluana Englaro has been called “Italy’s Terri Schiavo.” Englaro remained in a persistent vegetative state for 17 years until her father and doctors finally disconnected the feeding tube in 2009 after a ruling by Italy’s top court. Englaro’s death occurred while Italy’s Senate was in the midst of debating a law that would have forced the Udine hospice facility to resume tube feedings. Following the announcement of her demise, a moment of respectful silence was observed; it was then abruptly broken by lawmakers screaming, “Murderers!” Cardinal Javier Lozano Barragán, the Vatican’s equivalent of a health minister, said in an interview, “To withdraw food and water from [Englaro] means only one thing, and that is deliberately killing her . . . May the Lord forgive those who brought her to this point.”¹

In Canada, the Rasouli decision refers to an ongoing dispute between the physicians and the wife of a 60-year-old man who sustained severe and diffuse brain damage after postoperatively contracting



bacterial meningitis. The spouse disagrees with the medical team’s recommendation to discontinue life support and initiate comfort care.¹¹ The case is likely to be adjudicated by the Supreme Court of Canada, but the latest ruling prevents the doctors from Toronto’s Sunnybrook Health Sciences Centre from withdrawing a ventilator and tube feeding and withholding antibiotics. The lower courts have decreed that the physicians must seek approval from Ontario’s Consent and Capacity Board, an independent, extramedical tribunal that reviews and makes decisions on behalf of people who cannot act for themselves.

Can the involvement of the legal system be avoided? Treating accusations as risk management phenomena and robustly managing them by paying greater attention to communication and conscientious documentation can ameliorate, but not entirely forestall, dissension among health care professionals. Vigorously investigating and exposing sources of disagreement among stakeholders on the health care team can help these conflicts to be addressed within hospital walls. Hospitals can create multiple avenues—e-mails, voice mails, meetings—for staff to express concerns about patient care (a practice that is always preferable to staff members calling the local district attorney). There should be a low threshold for allowing and requesting ethics consultations, while grand rounds and other academic forums can deliberately present controversial topics to make the “hidden curriculum” point that it is acceptable to have and air differing views.

Although our survey spotlights accusations made against medical staff, concerns about the possibility of criminal or civil litigation should not become an excuse for treatment on demand, overtreatment of catastrophically ill patients, undertreatment

of pain, or denial of directives requesting a shift from curative to palliative care.¹² Even in the face of potential accusations of euthanasia or murder, clinicians ought not to be bullied into compromising their management of dying patients and won't be if they know their institution has protocols for dealing with accusations when they arise.

I want to reemphasize that the diverse opinions that medical staff hold about terminal care may reflect doctors' and nurses' international origins, as well as wide-ranging religious beliefs within American society. Furthermore, our pluralistic society maintains and respects these differing views. Even though the palliative medicine ethos is the current, predominant philosophy in American hospitals, it is important to appreciate that health care personnel who misunderstand clinical decisions or take offense with them can produce harmful allegations and generate distressing investigations. Medical staff have different faiths, backgrounds, and countries of origin, and all of these factors may contribute to these clinical disagreements. We live and work together in a pluralistic society that hopefully accepts and respects differing views.

Although caring for dying patients is always a serious matter, it would be a mistake to conclude that physicians ought to cease joking about death with their colleagues. Freud's understanding of humor seems newly trenchant. Levity must remain an acceptable defense mechanism in medicine for coping with the weightiest of medical duties: helping patients to die with grace and dignity.¹³

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